

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0046011</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Prairie Manor Nursing & Rehab Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>345 Dixie Hwy</u> <u>Chicago Heights</u> <u>60491</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Telephone Number: <u>(708) 754-7601</u> Fax # <u>(708) 754-8904</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Edward N. Slack, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>																									
IDPA ID Number: <u>810583511001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>12/01/02</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input checked="" type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County																									
	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____																									
	<input type="checkbox"/> "Sub-S" Corp.																										
	<input checked="" type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
IRS Exemption Code _____																											
In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u>																											

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>146</u>	Skilled (SNF)	<u>146</u>	<u>53,290</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>146</u>	TOTALS	<u>146</u>	<u>53,290</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>21,264</u>	<u>8,151</u>	<u>6,804</u>	<u>36,219</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>21,264</u>	<u>8,151</u>	<u>6,804</u>	<u>36,219</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 67.97%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)N/A

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/01/02

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 12/01/02 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 34 and days of care provided 6,507Medicare Intermediary AdminaStar Federal - Illinois

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	179,505	35,500	14,559	229,564		229,564	(5,877)	223,687		1
2	Food Purchase		145,163		145,163		145,163	(2,119)	143,044		2
3	Housekeeping	127,682	36,525		164,207		164,207	(1,704)	162,503		3
4	Laundry	36,058	5,295		41,353		41,353		41,353		4
5	Heat and Other Utilities			117,709	117,709		117,709	949	118,658		5
6	Maintenance	74,072		65,737	139,809		139,809	2,739	142,548		6
7	Other (specify):*							1,499	1,499		7
8	TOTAL General Services	417,317	222,483	198,005	837,805		837,805	(4,512)	833,293		8
	B. Health Care and Programs										
9	Medical Director			15,000	15,000		15,000		15,000		9
10	Nursing and Medical Records	1,568,912	59,824	58,579	1,687,315		1,687,315	6,038	1,693,353		10
10a	Therapy	224,175	760	525	225,460		225,460	321	225,781		10a
11	Activities	123,380	5,407	884	129,671		129,671	(479)	129,192		11
12	Social Services	69,589		5,878	75,467		75,467	(403)	75,064		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):*							6,664	6,664		15
16	TOTAL Health Care and Programs	1,986,056	65,991	80,866	2,132,913		2,132,913	12,141	2,145,054		16
	C. General Administration										
17	Administrative	41,255		30,185	71,440		71,440	6,973	78,413		17
18	Directors Fees										18
19	Professional Services			277,079	277,079		277,079	(196,505)	80,574		19
20	Dues, Fees, Subscriptions & Promotions			37,051	37,051		37,051	(20,859)	16,192		20
21	Clerical & General Office Expenses	89,545	2,894	115,719	208,158		208,158	26,905	235,063		21
22	Employee Benefits & Payroll Taxes			420,417	420,417		420,417	(12,665)	407,752		22
23	Inservice Training & Education			69	69		69		69		23
24	Travel and Seminar			1,035	1,035		1,035	611	1,646		24
25	Other Admin. Staff Transportation			1,017	1,017		1,017		1,017		25
26	Insurance-Prop.Liab.Malpractice			142,668	142,668		142,668	785	143,453		26
27	Other (specify):*							14,592	14,592		27
28	TOTAL General Administration	130,800	2,894	1,025,240	1,158,934		1,158,934	(180,163)	978,771		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,534,173	291,368	1,304,111	4,129,652		4,129,652	(172,534)	3,957,118		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Prairie Manor Nursing & Rehab Center #0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			9,097	9,097		9,097	453,461	462,558			30
31	Amortization of Pre-Op. & Org.			839	839		839		839			31
32	Interest			10,143	10,143		10,143	326,303	336,446			32
33	Real Estate Taxes			431,444	431,444		431,444	1,409	432,853			33
34	Rent-Facility & Grounds			390,000	390,000		390,000	(387,667)	2,333			34
35	Rent-Equipment & Vehicles			9,758	9,758		9,758	1,134	10,892			35
36	Other (specify):*											36
37	TOTAL Ownership			851,281	851,281		851,281	394,640	1,245,921			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		292,363	55,558	347,921		347,921	(5,822)	342,099			39
40	Barber and Beauty Shops			15,363	15,363		15,363	(15,363)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,935	79,935		79,935		79,935			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		292,363	150,856	443,219		443,219	(21,185)	422,034			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,534,173	583,731	2,306,248	5,424,152		5,424,152	200,921	5,625,073			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/03Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,355)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(324)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(12,110)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,000)	21		24
25	Fund Raising, Advertising and Promotional	(8,268)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(26,237)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (86,294)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	287,215		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 287,215		36
(sum of SUBTOTALS				
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 200,921		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1			1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
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91			91
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93			93
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95			95
96			96
97			97
98			98
99			99
100			100
101			101
Total			

STATE OF ILLINOIS

Summary A

Facility Name & ID Number **Prairie Manor Nursing & Rehab Center**# **0046011**

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			31		(1,925)	(2,480)		(1,503)				(5,877)	1
2	Food Purchase	(3,679)		(56)			1,586		30				(2,119)	2
3	Housekeeping					595			(2,299)				(1,704)	3
4	Laundry													4
5	Heat and Other Utilities			949									949	5
6	Maintenance			990	(146)	2,177	3		(285)				2,739	6
7	Other (specify):*				819	601	79						1,499	7
8	TOTAL General Services	(3,679)		1,914	673	1,448	(812)		(4,056)				(4,512)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			125	(68)	6,875			(894)				6,038	10
10a	Therapy					321							321	10a
11	Activities			17	(496)								(479)	11
12	Social Services				(499)	96							(403)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				5,777	887							6,664	15
16	TOTAL Health Care and Programs			142	4,714	8,179			(894)				12,141	16
	C. General Administration													
17	Administrative					6,917	56						6,973	17
18	Directors Fees													18
19	Professional Services	(6,103)		(190,420)			18						(196,505)	19
20	Fees, Subscriptions & Promotions	(8,268)		(12,596)			5						(20,859)	20
21	Clerical & General Office Expenses	(52,881)	354	10,552	138	68,622	120						26,905	21
22	Employee Benefits & Payroll Taxes				(12,043)			(622)					(12,665)	22
23	Inservice Training & Education													23
24	Travel and Seminar			456			155						611	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			785									785	26
27	Other (specify):*				5,258	9,334							14,592	27
28	TOTAL General Administration	(67,252)	354	(191,223)	(6,647)	84,873	354	(622)					(180,163)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(70,931)	354	(189,167)	(1,260)	94,500	(458)	(622)	(4,950)				(172,534)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation		448,409	5,052									453,461	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		316,359	9,943			1						326,303	32
33	Real Estate Taxes			1,409									1,409	33
34	Rent-Facility & Grounds		(390,000)	2,333									(387,667)	34
35	Rent-Equipment & Vehicles			1,104			30						1,134	35
36	Other (specify):*													36
37	TOTAL Ownership		374,768	19,841			31						394,640	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers						(683)		(5,139)				(5,822)	39
40	Barber and Beauty Shops	(15,363)											(15,363)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers	(15,363)					(683)		(5,139)				(21,185)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(86,294)	375,122	(169,326)	(1,260)	94,500	(1,110)	(622)	(10,089)				200,921	45

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011

Report Period Beginning:

01/01/03

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached List		See Attached List		See Attached List		
				Prairie Manor		
				Property LLC		Bldg. Partnership

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 390,000	Prairie Manor Property LLC	100.00%	\$	(390,000)	1
2	V	32 Interest	2,024	Prairie Manor Property LLC	100.00%	318,383	316,359	2
3	V	21 Bank Service Charges		Prairie Manor Property LLC	100.00%	54	54	3
4	V	21 Filing Fees		Prairie Manor Property LLC	100.00%	300	300	4
5	V	30 Depreciation		Prairie Manor Property LLC	100.00%	448,409	448,409	5
6	V							6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 392,024			\$ 767,146	\$ * 375,122	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$	Care Centers, Inc.	100.00%	\$ 31	\$ 31
16	V	05 Utilities		Care Centers, Inc.	100.00%	949	949
17	V	06 Maintenance		Care Centers, Inc.	100.00%	990	990
18	V	10 Nursing	19	Care Centers, Inc.	100.00%	144	125
19	V	11 Activities		Care Centers, Inc.	100.00%	17	17
20	V	19 Professional Fees	196,763	Care Centers, Inc.	100.00%	6,343	(190,420)
21	V	20 Dues and Subscriptions	13,323	Care Centers, Inc.	100.00%	727	(12,596)
22	V	21 Office & Clerical		Care Centers, Inc.	100.00%	10,552	10,552
23	V	24 Travel and Seminar		Care Centers, Inc.	100.00%	456	456
24	V	26 Insurance		Care Centers, Inc.	100.00%	785	785
25	V	30 Depreciation		Care Centers, Inc.	100.00%	5,052	5,052
26	V	32 Interest		Care Centers, Inc.	100.00%	9,943	9,943
27	V	33 Real Estate Taxes		Care Centers, Inc.	100.00%	1,409	1,409
28	V	34 Rent - Building		Care Centers, Inc.	100.00%	2,333	2,333
29	V	35 Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,104	1,104
30	V	25 Bus Reimbursement		Care Centers, Inc.	100.00%		
31	V	02 Food	56	Care Centers, Inc.	100.00%		(56)
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 210,161			\$ 40,835	\$ * (169,326)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06 Maintenance Salary	\$ 6,835	Care Centers, Inc.	100.00%	\$ 6,689	\$ (146)	15
16	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	819	819	16
17	V	10 Nursing Salary	38,297	Care Centers, Inc.	100.00%	38,229	(68)	17
18	V	10a Rehab Salary		Care Centers, Inc.	100.00%			18
19	V	11 Activity Salary	883	Care Centers, Inc.	100.00%	387	(496)	19
20	V	12 Social Service Salary	5,879	Care Centers, Inc.	100.00%	5,380	(499)	20
21	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	5,777	5,777	21
22	V	17 Administration Salary	30,185	Care Centers, Inc.	100.00%	30,185		22
23	V	21 Office Salary	10,594	Care Centers, Inc.	100.00%	10,732	138	23
24	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	5,258	5,258	24
25	V	22 Employee Benefits	12,043	Care Centers, Inc.	100.00%		(12,043)	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 104,716			\$ 103,456	\$ * (1,260)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary Salary	\$ 3,996	Care Centers, Inc.	100.00%	\$ 2,071	\$ (1,925)
16	V	03 Housekeeping Salary		Care Centers, Inc.	100.00%	595	595
17	V	06 Maintenance Salary		Care Centers, Inc.	100.00%	2,177	2,177
18	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	601	601
19	V	10 Nursing Salary		Care Centers, Inc.	100.00%	6,875	6,875
20	V	10a Rehab Salary		Care Centers, Inc.	100.00%	321	321
21	V	12 Social Services Salary		Care Centers, Inc.	100.00%	96	96
22	V	15 Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	887	887
23	V	17 Administration Salary		Care Centers, Inc.	100.00%	6,917	6,917
24	V	21 Office Salary		Care Centers, Inc.	100.00%	68,622	68,622
25	V	27 Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	9,334	9,334
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 3,996			\$ 98,496	\$ * 94,500

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$ 3,399	Care Centers, Inc. - Health Systems Division	100.00%	\$ 313	\$ (3,086)
16	V	02 Food		Care Centers, Inc. - Health Systems Division	100.00%	1,586	1,586
17	V	06 Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	3	3
18	V	17 Administration		Care Centers, Inc. - Health Systems Division	100.00%	56	56
19	V	19 Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	18	18
20	V	20 Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	5	5
21	V	21 Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	120	120
22	V	24 Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	155	155
23	V	32 Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	1	1
24	V	35 Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	30	30
25	V	39 Ancillary Enteral Supplies	1,281	Care Centers, Inc. - Health Systems Division	100.00%	598	(683)
26	V	01 Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	606	606
27	V	07 Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	79	79
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 4,680			\$ 3,570	\$ * (1,110)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 Employee Health Insurance	\$ 148,086	CCS Employee Benefit Group	100.00%	\$ 147,464	\$ (622)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 148,086			\$ 147,464	\$ * (622)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	01 Dietary	\$ 11,416	Xcel Medical Supply, LLC	100.00%	\$ 9,913	\$ (1,503)
16	V	02 Food	(226)	Xcel Medical Supply, LLC	100.00%	(196)	30
17	V	03 Housekeeping	17,463	Xcel Medical Supply, LLC	100.00%	15,164	(2,299)
18	V	04 Laundry		Xcel Medical Supply, LLC	100.00%		
19	V	06 Repairs and Maintenance	2,165	Xcel Medical Supply, LLC	100.00%	1,880	(285)
20	V	10 Nursing	6,791	Xcel Medical Supply, LLC	100.00%	5,897	(894)
21	V	10A Therapy		Xcel Medical Supply, LLC	100.00%		
22	V	12 Social Services		Xcel Medical Supply, LLC	100.00%		
23	V	21 Clerical and General Office		Xcel Medical Supply, LLC	100.00%		
24	V	22 Employee Benefits		Xcel Medical Supply, LLC	100.00%		
25	V	39 Ancillary	39,044	Xcel Medical Supply, LLC	100.00%	33,904	(5,139)
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 76,651			\$ 66,562	\$ * (10,089)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	1.00%	See Attached	0.77	1.40%		\$		1
2	Adam Vales	Owner	Administrative	11.00%	See Attached	0.76	1.90%	CCS Veba	590	22-07	2
3	Mark Steinberg	Relative	Administrative		See Attached	2.50	4.95%	CCI	960	17-07	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 1,550		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary	Patient Days	1,764,895	42	\$ 1,527	\$	36,219	\$ 31	1
2	05 Utilities	Patient Days	1,764,895	42	46,229		36,219	949	2
3	06 Maintenance	Patient Days	1,764,895	42	48,251		36,219	990	3
4	10 Nursing	Patient Days	1,764,895	42	7,018		36,219	144	4
5	11 Activities	Patient Days	1,764,895	42	838		36,219	17	5
6	19 Professional Fees	Patient Days	1,764,895	42	309,074		36,219	6,343	6
7	20 Dues and Subscriptions	Patient Days	1,764,895	42	35,428		36,219	727	7
8	21 Office & Clerical	Patient Days	1,764,895	42	523,091		36,219	10,552	8
9	24 Travel and Seminar	Patient Days	1,764,895	42	22,233		36,219	456	9
10	26 Insurance	Patient Days	1,764,895	42	38,230		36,219	785	10
11	30 Depreciation	Patient Days	1,764,895	42	246,194		36,219	5,052	11
12	32 Interest	Patient Days	1,764,895	42	484,531		36,219	9,943	12
13	33 Real Estate Taxes	Patient Days	1,764,895	42	68,681		36,219	1,409	13
14	34 Rent - Building	Patient Days	1,764,895	42	113,677		36,219	2,333	14
15	35 Rent - Equipment & Auto	Patient Days	1,764,895	42	53,777		36,219	1,104	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,998,780	\$		\$ 40,835	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06 Maintenance Salary	Direct Cost			213,393	213,393		6,689	1
2	07 Emp. Ben. - Gen. Serv.	Direct Cost			26,918			819	2
3	10 Nursing Salary	Direct Cost			976,718	976,718		38,229	3
4	10a Rehab Salary	Direct Cost			103,898	103,898			4
5	11 Activity Salary	Direct Cost			10,902	10,902		387	5
6	12 Social Service Salary	Direct Cost			306,863	306,863		5,380	6
7	15 Emp. Ben. - Healthcare	Direct Cost			174,348			5,777	7
8	17 Administration Salary	Direct Cost			1,191,200	1,191,200		30,185	8
9	21 Office Salary	Direct Cost			698,886	698,886		10,732	9
10	27 Emp. Ben. - Gen. Admin.	Direct Cost			238,998			5,258	10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,942,124	\$ 3,501,860		\$ 103,456	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary Salary	Patient Days	1,764,895	42	100,923	100,923	36,219	2,071	1
2	03 Housekeeping Salary	Patient Days	1,764,895	42	28,979	28,979	36,219	595	2
3	06 Maintenance Salary	Patient Days	1,764,895	42	106,088	106,088	36,219	2,177	3
4	07 Emp. Ben. - Gen. Serv.	Patient Days	1,764,895	42	29,264		36,219	601	4
5	10 Nursing Salary	Patient Days	1,764,895	42	335,028	335,028	36,219	6,875	5
6	10a Rehab Salary	Patient Days	1,764,895	42	15,649	15,649	36,219	321	6
7	12 Social Services Salary	Patient Days	1,764,895	42	4,661	4,661	36,219	96	7
8	15 Emp. Ben. - Healthcare	Patient Days	1,764,895	42	43,235		36,219	887	8
9	17 Administration Salary	Patient Days	1,764,895	42	337,043	337,043	36,219	6,917	9
10	21 Office Salary	Patient Days	1,764,895	42	3,343,864	3,343,864	36,219	68,622	10
11	27 Emp. Ben. - Gen. Admin.	Patient Days	1,764,895	42	454,813		36,219	9,334	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 4,799,547	\$ 4,272,235		\$ 98,496	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Care Centers Health Systems, Inc.
 Street Address 2202 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847) 905-3000
 Fax Number (847) 905-3030

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary	Billable Income	2,073,579		138,556		4,680	313	1
2	02 Food	Billable Income	2,073,579		852,614		4,680	1,586	2
3	06 Maintenance	Billable Income	2,073,579		1,311		4,680	3	3
4	17 Administration	Billable Income	2,073,579		25,000		4,680	56	4
5	19 Professional Fees	Billable Income	2,073,579		8,170		4,680	18	5
6	20 Dues & Subscriptions	Billable Income	2,073,579		2,312		4,680	5	6
7	21 Office & Clerical	Billable Income	2,073,579		53,285		4,680	120	7
8	24 Travel & Seminar	Billable Income	2,073,579		68,680		4,680	155	8
9	32 Interest Expense	Billable Income	2,073,579		571		4,680	1	9
10	35 Rent - Equipment & Auto	Billable Income	2,073,579		13,336		4,680	30	10
11	39 Ancillary Enteral Supplies	Billable Income	2,073,579		114,955		4,680	598	11
12	01 Dietary - Salary	Billable Income	2,073,579		268,554	268,554	4,680	606	12
13	07 Emp. Ben. - Gen. Serv.	Billable Income	2,073,579		34,942		4,680	79	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,582,287	\$ 268,554		\$ 3,570	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CCS Employee Benefits Group, Inc.
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847)905-4000
 Fax Number (847)905-4040

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Employee Health Insurance	Direct Allocation		\$	\$		\$ 147,464	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 147,464	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Xcel Medical Supply, LLC
 Street Address 2201 West Main Street
 City / State / Zip Code Evanston, Illinois 60202
 Phone Number (847)328-7600
 Fax Number (847)328-7615

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01 Dietary	Direct Allocation			\$	\$		\$ 9,913	1
2	02 Food	Direct Allocation						(196)	2
3	03 Housekeeping	Direct Allocation						15,164	3
4	04 Laundry	Direct Allocation							4
5	06 Repairs and Maintenance	Direct Allocation						1,880	5
6	10 Nursing	Direct Allocation						5,897	6
7	10A Therapy	Direct Allocation							7
8	12 Social Services	Direct Allocation							8
9	21 Clerical and General Office	Direct Allocation							9
10	22 Employee Benefits	Direct Allocation							10
11	39 Ancillary	Direct Allocation						33,904	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 66,562	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center # 0046011 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	First Choice		X	Mortgage			\$		\$	4,852,826			\$	316,360		1			
2																2			
3																3			
4																4			
5	See Supplemental Schedule															5			
	Working Capital																		
6	Diawa		X	Line of Credit						550,464					10,143	6			
7	Alloc. - Care Centers, Inc.		X												9,943	7			
8	See Supplemental Schedule															8			
9	TOTAL Facility Related							\$		\$	5,403,290					\$	336,446	9	
	B. Non-Facility Related*																		
10																10			
11																11			
12																12			
13	See Supplemental Schedule															13			
14	TOTAL Non-Facility Related							\$		\$						\$		14	
15	TOTALS (line 9+line14)							\$		\$	5,403,290					\$	336,446	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8							\$	\$			\$	8	
9												9	
10												10	
11												11	
12												12	
13												13	
14	TOTAL Working Capital											14	
	B. Non-Facility Related*												
15							\$	\$			\$	15	
16												16	
17												17	
18												18	
19												19	
20	TOTAL Non-Facility Related											20	

- * Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- ** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Prairie Manor Nursing & Rehab Center**# **0046011** Report Period Beginning: **01/01/03** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2002 report.		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$ 36,230	2
3. Under or (over) accrual (line 2 minus line 1).			\$ 36,230	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$ 396,623	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ 432,853	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998	8		
	1999	9		
	2000	10		
	2001	11		
	2002	444,062		
The 2002 tax bill amount of \$34,821 represents the portion of the real estate taxes applicable to the new owner.			13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
Alloc. - Care Centers, Inc. - \$1,409.47			14	PLUS APPEAL COST FROM LINE 5 \$ 14
RE Taxes paid during 2003 equals one month of responsibility (\$34,821) plus Care Centers allocation (\$1,409)			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Manor Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046011

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>32-17-131-007-0000</u>	<u>Nursing Facility</u>	\$ <u>444,062.02</u>	\$ <u>444,062.02</u>
2. _____	<u>Alloc. - Care Centers, Inc.</u>	\$ <u>68,681.49</u>	\$ <u>1,409.47</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>512,743.51</u>	\$ <u>445,471.49</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie Manor Nursing & Rehab Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046011

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet: _____

B. General Construction Type:

Exterior _____

Frame _____

Number of Stories _____

C. Does the Operating Entity?

☐

 (a) Own the Facility

☒

 (b) Rent from a Related Organization.

☐

 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

 (a) Own the Equipment

☒

 (b) Rent equipment from a Related Organization.

☒

 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒

 YES

☐

 NO

If so, please complete the following:

1. Total Amount Incurred:

5,035

2. Number of Years Over Which it is Being Amortized:

6.001

3. Current Period Amortization:

839

4. Dates Incurred:

12/01/02

Nature of Costs:

Financing Fees (\$5035)

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		2002	\$ 450,000	1
2	Alloc. - 2201 Main		2002	10,433	2
3	TOTALS			\$ 460,433	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.
 **Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		4,650,000	118,750		118,750		128,646	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		39,464	1,318		1,318		1,384	68
69	Financial Statement Depreciation			680			(680)		69
70	TOTAL (lines 4 thru 69)		\$ 4,689,464	\$ 120,748		\$ 120,068	\$ (680)	\$ 130,030	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 4,689,464	\$ 120,748		\$ 120,068	\$ (680)	\$ 130,030	1
2	Electrical Repairs	2003	5,460		20	182	182	182	2
3	Plumbing	2003	2,163		20	54	54	54	3
4	Painting Supplies	2003	1,318		20	22	22	22	4
5	Plumbing	2003	2,299		20	38	38	38	5
6	Painting	2003	922		20	12	12	12	6
7	Painting	2003	938		20	12	12	12	7
8	Electrical Work	2003	996		20	12	12	12	8
9	Generator Repair	2003	710		20	95	95	95	9
10	Tuckpointing	2003	950		20	95	95	95	10
11	Door Frames & Hinges	2003	1,580		20	158	158	158	11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	34

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	34

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	34

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 4,706,800	\$ 120,748		\$ 120,748	\$	\$ 130,710	34

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011

Report Period Beginning:

01/01/03

Ending:

12/31/03**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	146		2002		\$ 4,550,000	\$ 113,750	40	\$ 113,750	\$	\$ 123,229	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Prairie Manor Property LLC		2002		100,000	5,000	20	5,000		5,417	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
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54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,650,000	\$ 118,750		\$ 118,750	\$	\$ 128,646	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011

Report Period Beginning:

01/01/03

Ending:

12/31/03**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main LLC		2002	2002	\$ 14,378	\$ 358	40	\$ 358		\$ 369	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2201 Main LLC		2002	2002	13,312	666	20	666		721	9
10	2201 Main LLC		2003	2003	11,774	294	20	294		294	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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51									51
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 39,464	\$ 1,318		\$ 1,318	\$	\$ 1,384	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 901,989	\$ 331,937	\$ 331,937	\$	10	\$ 379,281	71
72	Current Year Purchases	37,578	8,257	8,257		10	8,257	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 939,567	\$ 340,194	\$ 340,194	\$		\$ 387,538	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Alloc. - Care Centers, Inc.			\$ 14,950	\$ 1,616	\$ 1,616	\$	5	\$ 11,764	76
77										77
78										78
79										79
80	TOTALS			\$ 14,950	\$ 1,616	\$ 1,616	\$		\$ 11,764	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 6,121,750	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 462,558	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 462,558	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 530,011	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Alloc. - CCI				2,333			5
6								6
7	TOTAL				\$ 2,333			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 7,537

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	Honda	\$ 563.40	\$ 3,355	17
18					18
19					19
20					20
21	TOTAL		\$ 563.40	\$ 3,355	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ _____

13. /2005 \$ _____

14. /2006 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 6,915	\$		\$ 6,915	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			13,132			13,132	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			10,262			10,262	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				216,986		216,986	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					25,249	75,377		100,626	13
14	TOTAL			\$		\$ 55,558	\$ 292,363		\$ 347,921	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 106,409	\$ 112,650	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,462,624	1,462,624	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	199,387	199,387	6
7	Other Prepaid Expenses	23,422	23,422	7
8	Accounts Receivable (owners or related parties)	368,338		8
9	Other(specify): See Attached Schedule	21,168	175,053	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,181,348	\$ 1,973,136	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		450,000	13
14	Buildings, at Historical Cost		4,550,000	14
15	Leasehold Improvements, at Historical Cost	16,269	116,269	15
16	Equipment, at Historical Cost	35,218	910,418	16
17	Accumulated Depreciation (book methods)	(9,097)	(556,150)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	5,035	97,022	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(839)	(3,476)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 46,586	\$ 5,564,083	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,227,934	\$ 7,537,219	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 709,704	\$ 723,314	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	550,464	550,464	29
30	Accrued Salaries Payable	596,763	596,763	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,666	9,666	31
32	Accrued Real Estate Taxes(Sch.IX-B)	396,623	396,623	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule		1,211,551	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 2,263,220	\$ 3,488,381	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,852,826	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 4,852,826	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,263,220	\$ 8,341,207	46
47	TOTAL EQUITY(page 18, line 24)	\$ (35,286)	\$ (803,988)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,227,934	\$ 7,537,219	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 103,576	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 103,576	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(138,862)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (138,862)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (35,286)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,179,185	1
2	Discounts and Allowances for all Levels	(1,585,270)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 3,593,915	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	810,248	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 810,248	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	16,470	13
14	Non-Patient Meals	3,355	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	219,219	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	606	19
20	Radiology and X-Ray		20
21	Other Medical Services	636,979	21
22	Laundry	4,228	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 880,857	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	270	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 270	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,285,290	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	837,805	31
32	Health Care	2,132,913	32
33	General Administration	1,158,934	33
	B. Capital Expense		
34	Ownership	851,281	34
	C. Ancillary Expense		
35	Special Cost Centers	363,284	35
36	Provider Participation Fee	79,935	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,424,152	40
41	Income before Income Taxes (line 30 minus line 40)**	(138,862)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (138,862)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Not Finished If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Prairie Manor Nursing & Rehab Center# 0046011Report Period Beginning: 01/01/03Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,276	1,368	\$ 39,497	\$ 28.87	1
2	Assistant Director of Nursing	1,095	1,119	28,485	25.46	2
3	Registered Nurses	12,481	13,412	284,985	21.25	3
4	Licensed Practical Nurses	24,492	26,261	485,758	18.50	4
5	Nurse Aides & Orderlies	81,614	87,406	713,612	8.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,840	13,222	224,175	16.95	8
9	Activity Director	3,493	3,812	56,389	14.79	9
10	Activity Assistants	8,419	9,116	66,991	7.35	10
11	Social Service Workers	4,415	4,960	69,589	14.03	11
12	Dietician					12
13	Food Service Supervisor	1,775	1,876	25,656	13.68	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,276	21,725	153,849	7.08	15
16	Dishwashers					16
17	Maintenance Workers	4,585	5,100	74,072	14.52	17
18	Housekeepers	16,764	17,765	127,682	7.19	18
19	Laundry	6,023	6,428	36,058	5.61	19
20	Administrator	1,032	1,064	41,255	38.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,945	6,352	89,545	14.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,790	1,975	16,575	8.39	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	207,315	222,961	\$ 2,534,173 *	\$ 11.37	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 14,559	01-03	35
36	Medical Director		15,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		617	10-03	39
40	Physical Therapy Consultant		210	10a-03	40
41	Occupational Therapy Consultant		180	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant		135	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	<u>Nurse Consultants - CCI</u>		38,297	10-03	47
48	<u>Activity / Soc. Services Cons. - CCI</u>		6,762	11-03/12-03	48
49	TOTAL (lines 35 - 48)		\$ 75,760		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 14,737	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides		4,928	10-03	52
53	TOTAL (lines 50 - 52)		\$ 19,665		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie Manor Nursing & Rehab Center

0046011

Report Period Beginning: 01/01/03

Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes		F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount
Candace Zannon (01/01 - 06/25)	Administrator	0	\$ 41,255	Workers' Compensation Insurance	\$ 74,780	IDPH License Fee	\$ 482
				Unemployment Compensation Insurance	54,563	Advertising: Employee Recruitment	3,263
				FICA Taxes	193,637	Health Care Worker Background Check (Indicate # of checks performed _____)	30
				Employee Health Insurance	76,693	Advertising and Promotion	21,592
				Employee Meals		Dues - ICLTC	4,396
				Illinois Municipal Retirement Fund (IMRF)*		Dues and Subscriptions	3,729
				Pension	112	Licenses and Fees	3,560
				Employee Physicals	60	Alloc. - Care Centers, Inc.	727
				Uniforms	171	Alloc. - Care Centers Health Systems	5
				Misc. Employee Welfare	6,386	Less: Public Relations Expense (
				Holiday Expense	1,350	Non-allowable advertising	(21,592)
						Yellow page advertising (
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 41,255			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 16,192
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)			
				\$ 407,752			
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Alloc. Care Centers, Inc. - Administrator			\$ 30,185	Description	Line #	Amount	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 30,185				
C. Professional Services				G. Schedule of Travel and Seminar**			
Vendor/Payee	Type		Amount				
Care Centers, Inc.	Bookkeeping		\$ 29,852				
Care Centers, Inc.	Home Office		122,920				
Care Centers, Inc.	Data Processing		4,380				
Care Centers, Inc.	Other Ancillary Services		17,560				
Keane Care	Data Processing		15,447				
ADP	Data Processing		6,258				
Various Others	Data Processing		5,039				
Frost, Ruttenberg & Rothblatt	Accounting		33,000				
Lawren	Legal		6,533				
Meyer Magence	Legal		100				
Care Centers, Inc.	Legal		13,351				
See Supplemental Schedule			22,639				
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 277,079	TOTAL		\$	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Prairie Manor Nursing & Rehab Center**

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC - \$4,396
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 46,254 Line 10 - 02
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 79,935
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 3,355
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? N/A
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.